The Pastoral Counselling Relationship

A touching place?

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Foreword

> The Western world has produced a race of untouchables. We have become strangers to each other . . . faceless figures in a crowded landscape, lonely and afraid of intimacy. To the extent that this is so, we are all diminished.[1]

This monograph is grounded in the belief that touch is an important but neglected part of our human heritage. Based on a dissertation submitted to St. John's College Nottingham for the Diploma in Pastoral Counselling, I seek to explore the potential as well as the dangers of touch for those involved in pastoral care and counselling. The dissertation arose out of a desire to understand and learn from my own experiences of touch, both positive and negative, while being counselled. Two years after writing the original, I am encouraged by the invitation to make it available to a wider audience.

In the process of my research, I read of therapists who sometimes felt moved to go beyond what they had been taught and who now advocate the use of touch in certain specific circumstances. This confirmed me in my belief that touch has a small but potentially creative place in pastoral care and counselling. Offered in the right way at the right time to the right person, it can bring an added dimension to the pastoral encounter and can sometimes move the process on in ways beyond imagining. While being aware of only scratching the surface of a complex and controversial subject, my hope is that other practitioners will be encouraged to reflect on their own practice regarding touch.

The title was inspired by a modern hymn written by John Bell and Graham Maule which starts:

Christ's is the world in which we move;
Christ's are the folk we're summoned to love;
Christ's is the voice which calls us to care,
and Christ is the one who meets us here.
To the lost Christ shows his face,
to the unloved he gives his embrace,
to those who cry in pain or disgrace,
Christ makes, with his friends, a touching place.[2]

1. Introduction

He touched her hand and the fever left her.

St. Matthew 18.5

'News at Ten' had just started when the phone went. It was my counselling supervisor, checking out a difficult situation I was dealing with. As I went upstairs to get the relevant information, I fell and almost collapsed, hardly able to breathe. My leg which had been very painful and hard for several weeks was suddenly much softer. In a flash I realised what had happened – a clot in my leg had moved to my lungs. I was suffering the effects of a pulmonary embolism. Meanwhile my husband was watching TV, unaware of what was happening.

Fortunately my survival mechanism took over and 'shock' rapidly turned into 'control'. I flung my stick downstairs to make a noise, calmly instructed my husband to dial 999 and then asked him to phone my supervisor to reassure her that I was alright. After several hours in the hospital's accident and emergency department, I ended up in a respiratory ward connected to a heart monitor, a heparin pump and an oxygen supply. Next morning the main part of the clot suddenly broke loose, spattering itself over my lungs. Only the fact of already being connected to life-saving equipment and the prompt action of the medical staff saved me. The next few days were a very anxious time for my family. Our daughter flew up immediately from London. Our son returned from Canada, bringing with him a love object – a teddy I had dressed for him in his favourite football team strip when he emigrated.

In hospital the days were busy; the nights frightening. I remember vividly one night in particular. I lay in bed, in a state of extreme anxiety, sweating, profusely, having wakened in terror from a nightmare about fighting with death. When I stretched out my hand for reassurance that I was still alive, the night nurse brusquely placed it back on my stomach and told me firmly to go back to sleep. Contrary to my previous experience of nurses, she appeared to perceive her task solely in terms of monitoring the machines supplying the drugs which, if I was lucky, might keep me alive. And I was grateful for her vigilance. But my spirit needed keeping alive too; I needed to be literally in contact with the pulse of a living being. I felt very isolated from the rest of humanity in my fight to stay alive.

As I lay there, too terrified to fall asleep in case I had another nightmare, I felt something furry brushing against my cheek. It was the teddy bear Andrew had brought back from Canada for me. It symbolised the love and prayers of all those who were concerned for me. I was too ill to be ashamed of getting comfort by cuddling a child's toy;

at that moment the teddy was all I had. But touching him was sufficient to calm me down and enable me to get some revitalising sleep.

Next morning the hospital chaplain responded to my outstretched hand. He took it and grasped it gently but firmly. I felt safe with him around. We talked a little – it's difficult through an oxygen mask. But holding my hand in his was his most significant contribution to my recovery. I felt connected in some mysterious way to a person who was close to God and so able to be a channel through which His life-sustaining force could flow to me.

These three incidents, occurring within a few hours of each other, illustrate the very meaningful difference that appropriate touch can make at a time of crisis to those of us for whom touch is a significant factor in our lives. But while touch can be especially appropriate at these times, when emotions are often beyond words, nurturing touch, as opposed to erotic touch, is essential for healthy fulfilment throughout life. It is particularly important in infancy and for the elderly confused, both of whom are limited in their communication by other means.

As a result of our upbringing many of us have not had the opportunity to develop our sense of, and sensitivity to, touch. There is a dark side to touch, and 'don't touch' messages from our parents, often said to keep us safe, may have stunted our growth and left us unaware of the importance to touch in human development and growth and in communication. Fear of causing more hurt to those who may have already been damaged, coupled with our own past tactile history, makes many of those involved in pastoral care/counselling wary of touching.

It will be sad if the possibility for harm caused by inappropriate touch is allowed to continue to overshadow the recognition of the potential for good of appropriate touch in pastoral care/counselling. As a pastoral counsellor who touches very occasionally, when I feel it is right to do so, I have found some of these moments to be turning points for clients in the counselling process. But there is clearly an obligation on all of us who contemplate the use of touch in our pastoral relationships to be well informed and sensitive to its effects so that we neither use it inappropriately, nor are afraid to touch when it could be a useful intervention.

Very little has been written on touch in pastoral care/counselling. Norman Autton's excellent book *'Touch: an Exploration'*[3] is the only account by a British author that I have discovered. I found no articles either in *Contact* or in the (American) *Journal of Pastoral Care* during the past fifteen years. In the SPCK *New Library of Pastoral Care* over the same period, only three out of the twenty-five books published even mention touch in their index. This monograph attempts to start to redress that situation, but in its brief length it can do little more than point to some of the relevant issues.

At the start, I want to acknowledge the difference in perspectives that I suspect men and women generally, by virtue of their gender

and upbringing, bring to this subject. For countless generations, men have been the providers and women the nurturers. The different perceptions of touch, by men as sexual and by women as nurturing, have both been necessary to enable the race to continue. Biologically the man impregnates the women and then goes off to provide for his family, leaving the woman as the main provider of nurturing. So while in recent times there is more diffuse role sharing, the cumulative effect of what Jung called our 'collective unconscious' still affects attitudes and causes most men to equate touch with sex, and the majority woman to equate touch with nurturing. An acceptance that men and women tend to perceive and experience touch differently, and that both sexes bring their own particular perception to the interactions between them, is a basic presupposition in the text.

After sharing my ideas for this monograph with both men and women, I realise that writing on this subject is even more open to misunderstanding than I anticipated. For example, in this present age, are mothers and fathers interchangeable in relation to their children? My response is sometimes, but not always. From the perspective of a newborn infant, there is a clear biological difference between the natural mother in whose womb s/he has grown, whose smell s/he intuitively knows and with whom s/he is in a symbiotic relationship, and the father whom s/he does not initially know. The father's involvement with the infant, from its birth, allows the father-infant bond to develop. As the infant grows the bonds with both father and mother have the potential to be equally nurturing and in 'good enough' circumstances there is the opportunity for the development of fulfilling relationships with parents of both sexes.

This monograph brings together two distinct but connected packages of information; the effects of touch or the lack of it in human development and recent research on touch in counselling and therapy. It suggests guidelines for the use of touch across the whole field of pastoral care and aims to stimulate those engaged in any part of that field to reflect on their own practice, bearing in mind both its potential and its dangers.

The following issues will be addressed:

- Making contact: touch in communication and healing
- The role of touch in the development of human behaviour
- The place of touch across the spectrum of therapies
- Issues arising in the context of touching a client
- Times when touch may be appropriate
- Times to avoid touch
- Practicalities: other issues
- Touch in pastoral care

2. Making contact: touch in communication and healing

Look, but don't touch.

My mother

This taboo, learned as a little child, was repeated in my initial training prior to seeing clients in a pastoral counselling centre. As a beginning counsellor eager to please, I obeyed. But obedience did not stop me being puzzled by this statement. After all Jesus, the 'wonderful counsellor', went about touching people and healing them. And my own deepest experiences, both within and outwith counselling, had been those in which touch was available, even if not actually used.

To even consider writing about such a 'prickly' subject as physical touch seems foolhardy. This statement itself may be a product of the effect of our non-touching culture which has incorporated into our language terms associated with physical touch as a substitute for the real thing. We talk in terms that we are afraid to experience: keeping in contact, rubbing along together, stroking people the right way. Yet it is touch which often grounds our experience in reality. I *needed* to touch that nurse's hand to reassure myself that I was still alive.

My hunch is that despite the predominating cultural taboo, touch remains a potentially valuable component in communication. In seeking to encourage and/or restore wholeness in others, I would feel restricted if my sense of touch was automatically rendered unavailable as a possible means of communication in the pastoral relationship. I would then be able to offer only a part of my whole person, body, mind and spirit, to the other. As a pastoral counsellor I want to feel free, in Brian Thorne's words to 'move between the worlds of the physical, emotional, cognitive and mystical without strain'.[4] This does not imply the *compulsion* to touch in every encounter, but rather the freedom to choose whatever part of the whole – body, mind and spirit – are appropriate in any particular situation. I would also limit my use of touch in the pastoral encounter to non-erotic touch.

Touch and varieties of approach to healing and wholeness

The biblical view of persons is a holistic one in which different aspects of the person (body, mind, emotions, spirit) are acknowledged to affect the other aspects. In practice, healing is often sought initially from a practitioner whose expertise lies in the area of the presenting problem. Setting aside illnesses which appear to be predominantly of physical origin, e.g. infectious diseases, I attempt to explore how

different therapeutic approaches relate to pastoral care and counselling.

Two possible ways of classifying therapeutic approaches are by

(i) their relative dependence on psychology and faith
(ii) their dependence on touch

I constructed *Diagram 1* (p9) with axes representing these two dimensions, and discovered that I could find examples of approaches to healing and growth in all four quadrants.

Quadrant 1 – psychology but no touch
Classical psychoanalysis and cognitive behavioural therapy are grounded in psychological principles and can proceed effectively without recourse to either faith or touch.

Quadrant 2 – psychology and touch
Massage and body therapies can produce changes in the mind through the application of touch irrespective of the faith of the client or the therapist.

Quadrant 3 – faith and touch
Sacramental ministry, including laying on of hands and the Eucharist, can enable healing by the combination of faith and touch irrespective of any knowledge of psychology.

Quadrant 4 – faith but no touch
Certain types of biblical counselling require faith on the part of person seeking help, but the body is viewed in a negative light and so touch is not used.

Where is pastoral care/counselling located? I would suggest that a pastoral carer/counsellor can theoretically be involved in all quadrants and with most of the varieties of healing mentioned here, for s/he has the freedom to utilise any combination of aspects of the spiritual, the intellectual and the material (here interpreted as faith, psychology and touch) as seems most appropriate. However, in saying this, I am distancing myself from the more extreme kinds of Christian or 'biblical' counselling where the compulsion to evangelise is strong, if not paramount, and where biblical revelation and personal faith often seem to be acknowledged as the only sources of wisdom on the human condition, in direct contradiction to MacNutt's statement that: 'God respects the natural process of psychological healing . . .'[5] I would regard any attempt to impose my views on the client as entirely against the spirit of acceptance and respect which Rogers emphasised as being core conditions for counselling.

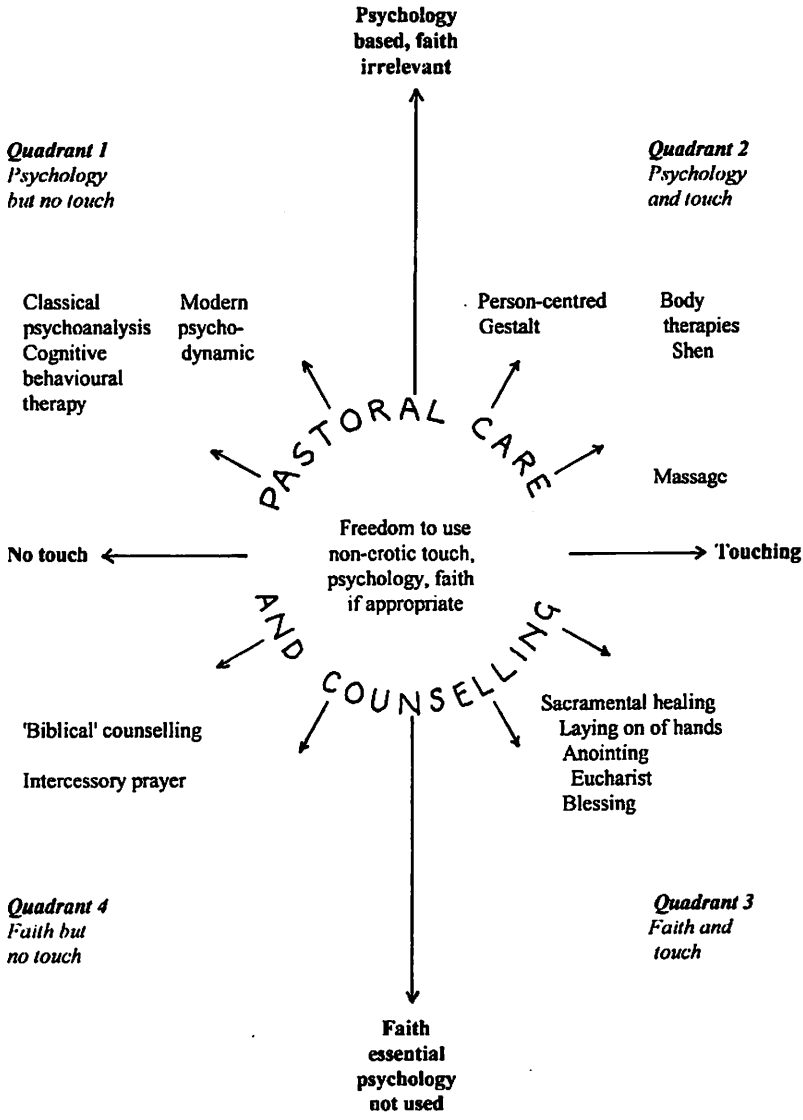

Diagram 1. Varieties of approach to healing and wholeness

The Christian healing ministry: a cautionary word

What is the relationship, if any, between the use of touch in pastoral care/counselling and in the laying on of hands? It is fundamentally different, or different only in degree? I do not know. It is one of life's

mysteries, but changed lives nevertheless bear witness to the fact that there are people for whom this latter type of healing ministry has been very real. In these cases the most appropriate response may be simply to give thanks, accepting that there are many experiences beyond our intellectual comprehension.

However, there are those whose experience of 'Christian' healing ministry has not been good. It is regarded with suspicion by many, in particular the medical profession and therapists who can find themselves treating its casualties. I pass no comment on the conditions in which healing does occur. But alongside David Howell's article 'Is anything wrong with Christian Healing?'[6] I place observations from my own limited experience that the failure of 'Christian' healing to bring people to wholeness is not uncommon. I notice that in many instances there is

(i) a lack of evidence of one or more of Roger's three core conditions, blocked out by what seemed to be a narrow judgemental attitude and apparent absence of emphatic understanding.
(ii) a lack of evidence of a basic understanding of psychology, of self-awareness, and of the dangers inherent in deliverance ministry.
(iii) a lack of appreciation of the need for supervision and accountability.

I draw the conclusion that pastoral counselling, in the sense that I am using it, has more in common with the best practices in secular counselling than with those in 'Christian healing' when the 'healing' is carried out by well-meaning practitioners who nevertheless may use inappropriate touch in ways that can be dangerous and detrimental in the long term.

Having located pastoral care/counselling within the general framework of approaches to healing, in the next section I address the issue of how a person's experience of touch in early life contributes to his/her development and behaviour in later life.

3. The role of touch in the development of human behaviour

> Where touching begins, there love and humanity also begin – within the first minutes following birth.[7]

> Being touched and caressed, being massaged, is food for the infant. Food as necessary as minerals, vitamins and proteins. Deprived of this food, the name of which is love, babies would rather die, And they often do.[8]

The division of a person into body, mind, emotions and spirit is an artificial concept, but a helpful one when focussing on one or two particular aspects of the person, as in the preceding section. However, we now need to return to the notion of the person as a whole entity, whose well-being is dependent on the well-being of all its constituent parts. When first published in 1927, Donovan's book *Dermatological Neuroses*,[9] with its hypothesis that what goes on in the mind can affect the body and can be manifested in the skin, was quite revolutionary. In our time the idea that the mind (psyche) can have an influence over the body (soma) is generally accepted, and has given rise to a whole field of psychosomatic medicine. Is there any evidence that this relationship between 'psyche' and 'soma' may operate in both directions?

Montague's distinctive contribution: what happens to the skin affects the mind

The standard reference book in the field of touch was written by Ashley Montague, a social scientist with wide interests. *Touching: the Human Significance of the Skin*[10] provides a fascinating and very readable guide to the effects of touching during the whole of the human life-cycle. From experience we know that a crying baby can often be soothed by being picked up and hugged, and that when a child bumps itself, kissing it or rubbing it better works. Physiological changes can, in fact, be detected after tactile stimulation,[10] and it is known that stimulation of the skin can both block pain pathways and release endorphins, the body's natural analgesics.

Montague was led to postulate the idea that the psychosomatic process *is* reversible, *i.e., what happens to the human body, specifically the skin, can affect the mind and hence our behaviour.* This is in agreement with the experiences described above. Being interested in human developmental behaviour, he set himself the task of seeking to answer the following questions:

1. What kinds of skin stimulation are necessary for the healthy development of the organism, both physically and behaviourally?
2. What are the effects, if any, of the want or *insufficiency* of particular kinds of skin stimulation?[11]

Applying the idea of healthy development and growth to clients, I jump ahead of Montague and ask my readers to consider this idea: *in inappropriate touch, e.g. abusive touch, affects the mind negatively, is it not also possible that appropriate touch can be therapeutic and nurturing? Could touching a client be a potent way of stimulating positive changes in the mind and hence encouraging positive behavioural change?*

The need for touch in mammals

With these questions in mind, let us return to follow Montague's detective work. Given that experiments on human infants were not possible, it was necessary for him to use data gathered from experiments on other mammals. The Harlows and others investigated how the development of infant monkeys was influenced by physical contact with their mother. Their findings included the following:

(i) Bodily contact with the mother monkey or mother substitute is the single most important factor in the infant monkey's healthy development; *tactile stimulation is, surprisingly, valued in preference to nourishment.* Infant monkeys chose to spend their time with a cloth mother surrogate (i.e. a cuddly mother) in preference to a wire mother irrespective of which mother lactated.[12]

(ii) Infant monkeys who were held and fed at the breast by their mothers developed in sexually healthy ways and proved to be good mothers themselves. *In contrast, inadequate mothering produced not only sexually inadequate offspring but next generation mothers who lacked the ability to bond with their own babies, even to the point of being violent towards them.*[13]

We turn now to explore the implications of these studies for human growth and development.

Human infants: tactile stimulation at the time of birth

Birth is a traumatic time for both infant and mother, the period immediately afterwards being critical in their bonding. Those who are prepared to both induce birth and then immediately remove the infant to a nursery to suit the convenience of the hospital are probably unaware of the psychological damage and the potential clients their actions may be helping to produce.

Babies born prematurely or by Caesarian section and who missed the tactile stimulation of the uterine contractions are at an additional disadvantage. They exhibit a relatively higher incidence of both physical and emotional dysfunction from birth onwards compared to infants

born 'normally'.[14] At the time of writing this I had a client suffering from the stress of continually being pushed into decisions and actions 'before she was ready'. I discovered she was born three months prematurely.

Immediately after birth, the infant initially receives almost all its sensory stimulation through the skin. The mother's loving touch and introduction of the infant to her breast provide optimal conditions for bonding and the reestablishment of the symbiotic relationship between mother and infant temporarily destroyed during the birth process. However, Harlow's discovery that loving touch is more important to the infant than breast feeding should reassure mothers for whom the latter is not a possibility and also encourage hesitant fathers to take an active role in nurturing their infant.

Tactile experience of infants in different cultures

Montague states that the degree of tactile stimulation a child receives depends on (i) the social norms of touching in the culture (and class) in which the child is raised and (ii) the individual family/environment.[15] It is interesting to note that there seems to be a correlation between the degree of friendliness and intimacy of adults in any given culture and the quantity of touch they received as children. For example, most Eskimos, who are carried naked inside their mother's bearskin until they can walk, tend to regard strangers as 'friends whom I have not yet met'[16] and greet them enthusiastically. Contrast this with the decreasing touching of infants in the developed world and their subsequent development into adults who find intimacy difficult.

I have broadened this train of thought on the correlation between touch in infancy and its effect on the predominating characteristics of the adult by comparing the lifestyles of infant monkeys with human infants reared in primitive and developed cultures (*Table 1;* p14). The data for this table is drawn from world-wide research studies.[17] It shows that the child-rearing methods of mothers in most primitive cultures accord more with those of monkeys (and of the 'good mothers' in Harlow's experiments on monkeys) than with methods in the developed cultures. Naturally there are exceptions in both directions, but interestingly enough they still support the hypothesis that tactile experience in infancy and childhood affects the personality of the adult.

The price of western culture

In western culture, something of the symbiotic relationship between mother and infant seems to have been lost. While the increasing participation of the father in the upbringing of children is to be welcomed, mothering is no longer seen to be of prime importance, particularly amongst the more highly educated, but in many cases something that has to be accomplished with minimum disruption to the woman's career. For those families where financial constraints make it necessary for

Table 1. Comparison of tactile experience of infant monkeys and human infants in primitive and 'developed' cultures

	Monkeys	Primitive culture	'Developed' culture
Priority of needs	Baby first.	Baby first.	Mother first.
Spontaneity	Spontaneous.	Spontaneous.	Increasingly conditioned.
Affection and nurturing	Freely given.	Immediate response to needs.	Restricted for fear of spoiling child and creating dependency.
Body	Naked.	Naked skin/skin, even Eskimos.	Clothed, often before feeding.
Body contact by day	On demand.	On demand, for majority of time at first.	Controlled by mother, separated in play-pen, pram, so mother can 'get on'.
Feeding	Breast on demand.	Breast on demand.	Controlled by mother. Breast feeding not always culturally acceptable inconvenient for working mothers.
Sleeping	Snuggle up together as family.	Together, closely bonded. Realise baby needs presence of adult.	Often alone, need for presence of adult disregarded. Crying upsets parents and baby.
Interaction with others	Freely available from an early age.	Looked after by older siblings. Peaceable interaction of extended family.	Smaller nuclear families may provide less interaction, particularly for an only child. Individualistic competition between families.

women to be wage-earners, the pressure to return to work can mean that from its birth, the infant is conditioned to fit into the family routine with minimal disruption, which can mean less handling.

I wonder if 'progress' in the developed cultures has been bought at a price, part of which is the valuing of a woman's capacity to be fully human in the biological sense? As women see themselves more and more as equal with men, rather than complementary, are they losing touch with the significance of their biological role as guardians of the nation's future emotional health? Is it becoming true that for many women, the joys of mothering, the sheer satisfaction and fulfilment produced by playing one's natural part in the chain of creation are

being lost, and that as a consequence their infants may be deprived of a rich tactile heritage? Do both men an women look to psychotherapy and counselling to rectify their losses in infancy, and, possibly in the case of women, as mothers too?

The effects of touching in early life on the subsequent development of the child

In good mothering, the mother is sensitive and responsive to her child's needs, including touch, and each experiences love, joy and satisfaction in their mutual interaction. With these conditions, healthy development is the norm. But sadly there are those who are not able to be even 'good enough' mothers to their infants. Though most maternal deprivation is in the form of insufficient mothering, i.e. a lack of response to the needs of the infant, there are other mothers who are overintrusive. They regard the child as an extension of themselves and resist all attempts by that child to move towards separateness and autonomy. For those unfortunate babies with a succession of mother substitutes there may also be inconsistency in their different responses to the baby. The results of inadequate mothering can present in a variety of guises in later life. Davis suggests that the number of clients whose problems may have their origin in deprivation of touch in early life is greater than is generally recognised.[18]

Montagu has drawn attention to the parallel between the behaviour of monkeys who received inadequate mothering and studies on abused children.[19] Parents who become child batterers and abusers were in most cases neglected and abused themselves as children, i.e. the problem is self-perpetuating. Unfulfilled needs for pleasure through loving touch in early life, particularly in men, can lead to violent/abusive means of procuring sexual satisfaction when adult. I am not, of course, saying that *all* abused children develop into abusing adults; many, particularly women who were abused when young, succeed in their determination to make sure that their own children will not suffer what they themselves went through.[20]

Changes in patterns of childcare

Up until 1920, almost 100% of infants in foundling institutions across America died before reaching their first birthday. At this time child-rearing in America was under the influence of behaviourist psychology which advocated a rigid schedule for infants including minimal handling. In contrast, babies in poor homes brought up by loving mothers who followed their instinctive reactions often survived and flourished. Gradually the importance of handling, caressing and cuddling an infant, a fact known innately by countless generations of mothers, was recognised by doctors, the majority of whom were male. A visit

by Dr. Fritz Talbot of Boston to the Children's Clinic in Dusseldorf played a significant part in the changing pattern of childcare:

> The wards were very neat and tidy . . . (apart from) . . . a fat old woman who was carrying a very measly baby on her hip. 'Who's that?' inquired Dr. Talbot. 'Oh, that is Old Anna. When we have done everything we can medically for a baby, and it is still not doing well, we turn it over to Old Anna, and she is always successful.'[21]

Dr. Talbot took Old Anna's method back to Boston with him and introduced it to America as 'tender, loving care'.[22] The new ideas caught on and, by 1945, Dr. Spock's *Baby and Child Care* was published.[23] It was destined to replace the long-standing behaviourist books as the popular book on childcare. Can we see in this new attitude a forerunner of Roger's three conditions for effective therapy – acceptance, empathy and unconditional positive regard? Do some clients come into therapy to seek healing for wounds unwittingly inflicted on them by well-meaning but misguided parents?

As Rogers gained experience and developed new skills, he

> began to shape his own distinctive approach to helping others, a way that offered a revolutionary alternative to the controlling techniques of behaviourism and the protracted questing of Freudianism.[24]

In the next chapter I compare the attitudes to touch of the three broad schools of psychotherapy.

4. The place of touch across the spectrum of therapies

Touching is not a technique; not-touching is a technique.[25]

Therapy may be directed primarily towards the body (e.g. 'hands-on' therapies like osteopathy and chiropractic) or towards the mind and emotions (e.g. 'hands-off' therapies like classical psychoanalysis and cognitive therapy). Between these two clearly defined ends of the therapy spectrum, however, there is a large grey area in which the question 'is touch appropriate?' is a valid one. Although in some therapies, e.g. the Alexander technique and Shen, the interaction of body, mind and spirit and hence the appropriateness of the use of all three in therapy is acknowledged, for predominantly 'talking therapies', the question of whether or not to touch can often lead to strong disagreement among practitioners.

This divergence of opinion arises out of the multifactorial nature of the dilemma. It is dependent among other things on

(i) the theoretical stance of the therapist
(ii) the actual situation
(iii) the present relationship between therapist and client
(iv) their individual life experiences
(v) their resources.

Each school of therapy has its own general attitude towards the use of touch in therapy which arises out of its perception of the nature and importance of the therapeutic relationship.

The nature of the therapeutic relationship

Whether intentionally or not, the broad differences in the nature of this relationship across the three main groups of 'talking' therapies, psychodynamic, cognitive-behavioural and humanistic, were vividly etched on my memory by the methods of presentation used during my training. The *psychodynamic* tutor chose to show us a film of *another* therapist at work: learning 'at an emotional distance;. In relating to the client, the therapist appeared concerned but gave very little of herself in the relationship. Our exposure to *cognitive-behavioural* therapy was even more remote. We were given a lecture and lists of procedures; it was a model of scientific method. I have no recollection of anything other than cognitive input which I could have read from a book. The tutor leading the *person-centred* session 'did it herself'. She sat comfortably on the floor in the centre of the circle of students, invited her

Table 2. Comparison of tendencies to touching in therapy

School	Predisposition to touch	Advantages	Disadvantages in extreme cases
Psychodynamic	Cautiously, only after consideration.	Abstinence keeps focus on client and discourages gratification at the expense of insight.	Therapist can appear as cold and distant; can model rejecting parents. Possible to produce insight without movement.
Cognitive-Behavioural	Perceived as irrelevant and inappropriate.	CBC appeals to clients afraid of intimacy. Gives them feeling of security.	Lack of modelling. Can be experienced as cold and clinical.
Person-centred	Prepared to invest whole of self including appropriate touching.	Reality of therapist gives chance of real relationship.	With incompetent and/or undisciplined therapist, the supreme importance of the relationship can take precedence over the actual 'work'.

within any one school, experienced therapists are generally more effective than inexperienced therapists. Dryden invited a number of noted practitioners trained in different schools to describe 'key cases' in which the conflict they experienced led to substantial developments in their theoretical understanding and/or practice.[36] Is it significant that across all the schools, increasing experience seems to bring a deepening awareness of the value of the client/therapist relationship? I quote from practitioners trained across the spectrum.

Aveline (multidisciplined) quotes Guntrip (modern psychodynamic):

> . . . (the therapist needs to be) a sufficiently real person to the patient to give him a chance of being a real person himself. . . .[37]

Wessler (originally Rational Emotive Therapy, a forerunner of CBC):

> . . . we have reaffirmed the tenet that psychotherapy is an intimate human relationship . . . We have found that none of the dire predictions about iatrogenic (*therapist-induced*) dependence and catering to neurotic needs for love and approval that we learned from RET have been fulfilled. . . .[38]

Rowan (humanistic):

> I found myself taking more risks and using more of myself than I had ever done before . . . it was as if I had given myself permission to break the bounds.[39]

Could there be a link between the greater effectiveness of experienced practitioners and the evidence that as their experience grows, many move towards an increasing convergence of approach-attitude to the client, accepting the centrality of the therapeutic relationship which may come to include the use of touch? The next section will address general issues concerning touch, common to all practitioners.

5. Issues arising in the context of touching a client

> As a critical component of human experience and communication, touch and its attendant issues cannot be avoided . . . the question may not be whether or not therapists *should* touch their patients but rather *how* touch is utilised and processed in therapy.[40]

Touch is a privilege and an invasion of the client's space which should not take place in normal conditions without permission/invitation. By non-erotic touch I mean contact between counsellor and client which does not result in either being sexually aroused. With the majority of people, this may include the counsellor making contact with the hand(s), arm(s) shoulder, knee or upper/lower back of the client. It is a nurturing act as opposed to a sexual act.

Research into touch in therapy

In the context of this monograph I am using counselling/therapy interchangeably, while recognising that a psychotherapist works at greater depth. I failed to find any British references to research into touch in therapy during the last decade, and only a handful from abroad.[41] In these it was disappointing to find such a heavy bias towards erotic touch. Research on the effect of non-erotic touch on the therapeutic process seems to be a field still waiting to be explored. However, there are signs that there is a small but growing movement towards the nurturing aspects of touch as an increasing number of women enter the field and begin publishing.

In Britain, as in much western culture, touching is a very emotive and controversial subject. Its complexities are so great and run so deep into the human psyche that it is difficult to lay down general guidelines. However, within the therapeutic relationship there are certain issues which should be addressed by all responsible practitioners before touching a client.

The expectations of the client

Clients come into counselling with differing needs and may have expectations of the kind of relationship (with its implications for the role of touch) they hope/need to form with the counsellor if the counselling is to be of help to them. The sensitive counsellor takes his/her lead from the client. Some clients do best in a warm, empathic atmosphere; others, particularly men, with a fear of intimacy, prefer an emotionally cooler atmosphere. While most counsellors have their own preferred

emotional climate, they need to be flexible. Appropriate touch will feel comfortable for both client and counsellor. Lazarus recommends that '... whereas a Rogerian will offer warmth and empathy to all, a multimodal therapist will ask "what type of relationship is this person apt to respond to?"'[42]

It is reasonable for the client also to have ethical expectations, that the counsellor will act professionally and will have skills appropriate to the service offered. Although inter-related, ethical issues relating to touch can be categorised under (i) the safety of the client, leading into the male perception of the touch-sex linkage and (ii) the competence of the counsellor, allied to the female perception of the touch-nurture link. I will consider each in turn.

Ethical issues: (i) the safety of the client

> Counsellors should take all reasonable steps to ensure that the client suffers neither physical nor psychological harm during counselling. Clients should not be exploited sexually, emotionally or in any other way.[43]

Non-sexual exploitation can occur when any counsellor seeks to gratify their own needs (in this context for non-erotic touch) at the expense of the client, be it the same or different sexed client. In addition, for the latter, a complicating factor is the different perceptions of touch by the two sexes. In her researches into power touch, Nancy Henley recognised the complexity of the power/intimacy/sex relationships and concluded that 'women do not interpret man's touch as necessarily implying sexual contact, but men interpret woman's touch that way.'[44] This is in accordance with Abbey and Melby's findings and explains how touch between a male counsellor and a female client can be misinterpreted by each party.[45]

In his book, *'Sex in the Forbidden Zone'*, Rutter defines sex in this zone as 'any sexual contact that occurs within professional relationships of trust'.[46] As victims, it is not surprising that it is predominantly women who have an interest in publishing research in this area. In Nanette Gartrell *et al.*'s study of 1057 male psychiatrists who responded to a questionnaire, 7.1% *admitted* to having sexual contact with a patient.[47] In addition, most men are repeaters. The problem is heavily biased towards exploitation of women; 96% of sexual exploitation by professionals occurs between a man in power and a woman under his care.[48] Rutter states that 'the allure of the forbidden is a central theme of male sexual psychology.'[49]

An understanding of the complexity of the issues involved leads to a greater awareness of the low activation energy required to initiate the process and the speed of its progress once started. I have compiled *Table* 3 (p24) to summarise male and female perspectives on 'sex in the forbidden zone'. It refers specifically to a male therapist and a female client.

The responsibility for preventing sex in the forbidden zone is firmly

Ethical issues: (ii) the competence of the counsellor

> Counsellors should monitor actively the limitations of their own competence through counselling/supervision support. . . . Counsellors should work within their own limits.[56]

Responsible therapists are aligned across a spectrum ranging from those who would not consider touching any client under any conditions, those who only touch after careful consideration of the total situation and those who touch freely, eg. some person-centred therapists and the body therapists. In any particular diad of counsellor and client, the optimal touch which could potentially benefit the client (and here I am excluding gratification at the expense of insight and growth) may be unavailable because either the counsellor cannot give it or the client is unable to receive it. Therapists bring with them their own attitudes to touch, based on their personalities and their tactile history.

> There will always be those therapists, who would never feel comfortable, by temperament or philosophy, physically touching at patient- . . . such a delicate interaction cannot be artificial or forced . . . ultimately it is our honesty about out limitations as well as our strengths (which) helps clients accept their realities as well.[56]

Many therapists have developed their remaining senses so that they 'touch' their clients by other means, e.g. by their eyes, their body language, the tone and quality of their voice. A non-touching approach is appreciated by clients for whom touch is threatening, but a counsellor who cannot touch under any circumstances can be at a disadvantage when working with clients for whom touch is a significant means of communication. Competent therapists will have evaluated their own current position as regards the use of touch, and a trusting supervisory relationship where the both the dangers and potential can be squarely faced safeguards both counsellor and client.

As stated earlier, the safety of the client and the competence of the counsellor are inter-related. The safety of the client is optimised when the counsellor

- has fulfilling relationships outside his/her work
- has undergone personal counselling/psychotherapy in their training
- has regular supervision.

The provisions of this threefold support network minimises the potential harm we may do to our clients, particularly by manipulation/abuse in order to meet our own unfilfilled needs. It recognises that no-one is perfectly mature; we are all wounded healers. In practice, wounds that we have worked through can be integrated into our experience and so enable us to help the client more effectively. But our unhealed wounds may be a stumbling block in the client's process – I

have found a previous supervisor's remark 'when the client's stuck it's often you that's stuck' very true.

Having set out the issues surrounding the use of touch in general terms, in the next three sections I will address practical matters, in particular whether touch is appropriate or not in specific situations.

6. Times when touch may be appropriate

> With very few exceptions, touch is an adjunct to – not a substitute for – talking and listening . . . in my own work I'm a talker 90% of the time, a toucher maybe 10%.[57]

This quote by Older, a medical practitioner and psychotherapist who has researched and advocated the use of touch in counselling and psychotherapy over many years, serves to remind us that it is nevertheless to be used with discretion. There is general agreement that it is wise to refrain from touching until a relationship is established, apart from in a crisis situation. Beginning counsellors who are counselling clients of the opposite sex are reminded of the issues raised in the previous section on the safety of the client, particularly the ease with which misunderstandings can occur and the speed at which a situation can get out of control. While the guidelines were written originally for pastoral counsellors, many are applicable to similar situations in the more general field of pastoral care. I illustrate the guidelines by examples from my own experience, which are indented and in italics.

A. as a ritual in the social sense, e.g. a touch on entering or leaving

> *Paul, a professional man and recent widower, allowed himself to cry freely during sessions, but before leaving got himself together and offered me a warm handshake. I believe this could have served several purposes for him: awareness of boundaries, his need for non-erotic touch, acknowledging his appreciation, signalling putting his emotions away and re-entering into life in the outside world. I felt comfortable counselling him.*

This is an example of minimal touch being used each time the client is seen. The following examples are of situations where touch may only be used occasionally.

B. in crisis situation, e.g. grief, trauma, depression or other acute illness, to ground the client and provide reassurance that they are not alone in the crisis

> *Mary, a nurse and a devout Catholic, was still so devastated by her husband's sudden death four months previously that she sobbed quietly right through the first counselling session. She spoke in a lifeless monotone. Her body language reminded me of a child who had completely lost hope. As I was leaving, her eyes looked at me pleadingly. I felt an urge to depart from my usual practice of asking, and held my arms open. She came into them and put her head on my shoulder. We stood in silence for*

a minute or two. I felt a sense of mystery as though I was somehow being used to re-energise her. Finally she stood on her own and said 'I will get over it, with your help'. It only took five sessions for her to be functioning again and back at work. By a strange coincidence, I found myself on her ward when I was ill. It was then her chance to minister to me.

I see similarities between this experience of re-energising Mary and my hand being held by the chaplain, as described in the introduction. In both cases the message to the helper seemed to be 'My strength has left me. I am beyond thinking. Please kick-start me into action by an infusion of the life-sustaining force which I see in you.' My experience, both as a counsellor and as a patient/client is that touch is the means by which some people in crisis situations, whose hold on life appears very tenuous, can be loved back into life. And when they share a common faith, the experience can be all the more powerful.

C. to focus the client's attention if wandering[58]

This can have a variety of causes, physical, tiredness or sickness, mental, inability to understand what is happening, or following a train of thought and racing ahead, overwhelmed by feelings or feeling nothing. A gentle touch on the hand, arm or knee can ground the client and bring them back into the present.

D. to emphasise a verbal statement[59]

An idea/statement can be more readily accepted if it is accessible to two or more senses simultaneously. Speaking is the normal pathway into the mind; touching makes contact with the heart.

Holding Judith's hands while I told her I accepted her and her story seemed to help her believe me.

Judith (at the next session): 'You didn't just tell my mind that you accepted me; when you took my hands my body heard it too.'

E. to unblock a client[60]

It was Freud who discovered in his early days that skin-to-skin contact could release repressed material.

After several sessions, Amy, a house-bound semi-invalid, told me in a resigned voice that she was unable to express her anger towards her late mother for fear that the strength of it would blow her to pieces. Recalling a similar experience from my own therapy, I offered to hold her if she thought it would help. She agreed, and appeared to be out of control of

her body as she screamed at a photo of her mother. I was very apprehensive in suggesting it, and scared while it was happening, but it was the turning point in her therapy. Gradually, over a period of months she regained her self-esteem and health, and was once again able to go out and take part in the life of the local community.

7. Times to avoid touch

> Appropriate touch becomes inappropriate when given at the wrong time, in the wrong dose, or to the wrong person.[61]

This section is based on Older's headings on common reasons not to touch.[62] Any touch which is undertaken should be consistent with the needs of the client *at that moment,* while remaining aware of the total situation and the goal of eventual termination of counselling. Physical contact can be used to avoid feelings, and some clients act out their impulses (e.g. asking to be touched) as a defence against experiencing the tensions and conflicts that underlie them. Counsellors who comply with every client's desire to be touched without assessing each individual situation may in the long term be denying their clients the chance of healing and growth.

A. when the therapist does not want to touch, for whatever reason

Apart from facial expression, it is much harder to lie with the body than with words.[63] Many therapists e.g. Mintz,[64] Corey *et al.*,[65] stress that any lack of genuineness in touching by the therapist will be picked up by the client to the detriment of therapy. Self-awareness on the part of the therapist as to why she does not want to touch can give insight which can move the therapy on.

B. when the client does not want to be touched

I assumed before visiting my first blind client that the use of touch would be important in our communication. I was wrong. In our initial contract making, Sarah told me how her previous bad experiences of touching, resulting from being unable to see people approaching her, meant that she wanted my assurance that I would not *touch her. I lacked confidence in my verbal ability alone to assure her I was 'for her' s next time took a bunch of fragrant flowers from my garden. She was delighted, smelling them with obvious enjoyment. I believe that in involving smell as an alternative second sense, the flowers were a symbol to a person who had no access to body language that I cared about her but respected her request not to be touched.*

I sensed from another client's conversation that she was badly missing being touched and asked her if she would like a hug. 'I would love one' she said, 'but I couldn't because I don't know you.' As we parted she said 'Thanks ever so much for offering a hug. It helps to know you understand how I'm feeling.' We did good work together.

In contrast, a widow who also was feeling the physical loss of her husband deeply accepted the offer of a hug without hesitation. I could feel her gradually relax in my arms. Afterwards she said 'You know, nobody has touched me for over a month. I've felt like a leper.' From there we went on to discuss how a widow who is particularly sensitive to lack of touch can adapt to the loss of her sex life and how and from who she could ask for appropriate touch. She progressed rapidly after that.

These examples demonstrate that often the best way to find out if touch would move the client on is to ask them. However, there may be other times, specified below, when the therapist believes touch would not be helpful at that particular moment, even though the client asks for it and the basic humanity of the therapist longs to respond. This is where the self-awareness and self-discipline of the therapist is essential.

C. when touch would encourage the client to avoid the therapeutic process altogether by being content with infantile gratification

I am aware that when counselling bereaved young women of around my daughter's age I have to discipline myself to remember I am present as a counsellor and not primarily as a mother figure. However, an awareness of the transference and countertransference issues, which may include some dependency in the early stages, can make a positive contribution to the counselling process.

D. when the client has not reached the depths of their pain and touch could block further progress[66]

Jenny, a young waiflike widow, used to look at me with large appealing eyes. Her story moved me deeply. My heart went out to her and I longed to take her in my arms, as I would my own daughter, but both my training and my guts told me 'no'. I checked and found she had friends who hugged her. A year later, although she was back at work and beginning to force herself to socialise again, I felt I had been unable to help her descend into the depths of her pain and work through it. I sometimes wonder if she might have made better progress if, like with Mary, I had held her at the start.

E. when the therapist feels manipulated by the patient

Pat was playing 'poor me'. I refused to be drawn. She burst into tears. I remained quiet and waited. Eventually she realised I was not going to accept her role of invalid. As we started looking constructively at ways she could care for herself when feeling low, she began to internalise my confidence in her capacity to develop in more healthy ways. That was the

start of the establishment of a good therapeutic relationship and fruitful counselling.

F. when the therapist is aware of the temptation to manipulate the client

G. when touch involves the counsellor colluding with the client because their own pain is triggered

These last two situations can happen not only with male counsellors (as previously indicated), but also with female ones, especially those who basic needs to be nurtured and to nurture others have not been, or are not being fulfilled. At the upper end of the age spectrum, there must still be many counsellors whose mothers were influenced by the Truby King system of baby care. Basically, King believed in a rigid four hourly system of feeding and minimal handling of the infant. Some counsellors may be unaware that their desire to nurture their clients may originate in unfulfilled needs of their own rather than the needs of the client. This is a case where good supervision is essential in the interests of both client and counsellor.

8. Practicalities: other issues

In sections six and seven I dealt with the more straightforward examples of when touch might be used appropriately and when it might be better avoid. I now turn to some situations where the issues are more complex, review my own attitude to touching clients and suggest areas for further research.

Regression work and its hazards

My own experiences have led me to the conclusion that the effect of inappropriate touch, or inappropriate failure to touch, if it evokes preverbal memories, can be far more traumatic than verbal communication and needs to be treated by some 'touch happy' therapists with a seriousness which acknowledges this.

> *I myself have experienced considerable distress, once by being touched inappropriately and another time by having touch withheld. In each case preverbal memories were triggered which required another therapist to resolve.*

In the light of these experiences I question Willison and Masson's statement that touch 'does not lead to negative consequences in any counselling context',[67] together with Kertay and Reviere's statement that 'like all forms of interaction, touch and its issues are "grist for the mill", no more and no less than any other form of interaction.'[68] It may be that an awareness of the potential danger for both client and therapist is one reason why so many therapists are reluctant to enter the field of touch.

However, there can be times when withholding touch may be detrimental to the therapeutic process. One such example is when refusal triggers such overwhelming memories of early rejection that they prevent the client functioning in the present. In regression work touch may well be appropriate when it is recalled that small children often need touch *in addition* to verbal comfort to quieten them.

Another example is that of a client so afraid of a memory (often preverbal) that they cannot look at it without the safety of being 'held' by touch. Like Freud before him, Liss, a medical doctor practicing psychotherapy, has found that for many people, even a small amount of body contact enables deeper feelings to surface. There is a limit to the pain we can bear at any one time; touching can make some people feel safer and so allow them to experience deeper pain.[69]

> *Jane had approached two different therapists with whom she had previously been in therapy and had asked each of them if they would be prepared to hold her while she looked at a long-standing nebulous fear. When they*

tried to discuss her request with her all she could say was that she dare not look the fear in the face unless she was held together by someone, because it was so powerful it would destroy her. Neither therapist would consent.

Once I agreed that she could sit close to me, and that I would hold her if necessary, she gained sufficient confidence to start on her own. She took a deep breath and her hands moved spontaneously to her genitals. As the work unfolded, it transpired that she had picked up her mother's terror of the pain of intercourse and her fear of conception and birth. Once understood, the fear disappeared and has not returned. Jane was able to talk with her mother afterwards and discovered that her mother had in fact only had intercourse once in her life. Luckily for Jane the attempt was successful!

I wonder if Jane's previous therapists were afraid of being manipulated, or of being sucked into a mother/infant or lesbian relationship, because they were both experienced. I trusted her and felt her request was straight and nonmanipulative.

Mintz, an experienced therapist, advocates symbolic mothering including touching for clients and histories of maternal deprivation whose difficulties may go back to the pre-verbal stage.[70] In long-term therapy appropriate touch can be part of the reparenting process. The modelling of healthy, nurturing touch by the therapist can not only heal the wounds inflicted by the client's own parents, but also provide an alternative role model for presently and/or potentially abusing parents, and so break into the vicious circle of abuse.[71] There would naturally be a discussion and a clear understanding by the client of the significance of the therapist's touch – nonerotic, supportive, nurturing, before it was used as part of the therapy.

Review of my own counselling stance

What has been the effect of these investigations on the way I use touch with my own clients? Although I enjoy touching and being touched in life outside the counselling room, my training has led me to touch very little within the counselling relationship. This situation has changed little since writing the original dissertation. But my sensitivity to the potential and hazards of touch has increased. I feel that in counselling I am increasingly trusting my 'self', not a mask but my real authentic self. That includes my capacity to reach out and touch clients in a non-erotic way, if appropriate, as one human being to another. It is when I am most truly my whole self that I am most free to be a channel of God's grace to others. In general, I don't know if or how I will touch in a session any more than I know in advance what I will say. Having learnt the rules, and prepared myself, I go in, concentrate on the client and trust my intuition and insights. In Rowan's words:

> . . . the practitioner always has to follow intuition and the sense of

what is fitting, in the session itself. This is the eternal paradox, that *the better our plan and preparation, the better it is to let go of it in the actual moment of encounter* . . . unless we are flexible enough actually to try new things – things we didn't learn in our training – therapy will never change or develop. And we will never change or develop as therapists.[72]

And for those of you to whom this quotation sounds somewhat risky, I invite you to join with me in balancing it with Elland's words of wisdom:

> if in doubt about whether touch is appropriate, one should imagine oneself on camera with a panel of well informed senior colleagues watching.[73]

It seems a good safeguard, while giving the freedom to give such touch as one is prepared to justify afterwards to one's own supervisor.

Further investigation

I offer the following suggestions as possible topics for investigation:

(i) Is there any correlation between the way a therapist experienced touch as an infant and in the family and the school of therapy they chose? Do therapists choose a school that fits how they are, or one that makes up for the deficiencies in their upbringing?
(ii) What effect does experience of therapy, both as a client and as a practitioner, have on those who never touch and those who touch a lot? Is there any move towards a central position?
(iii) Are there certain types of client and specific situations in which touch seems can be the most effective and appropriate response?
(iv) What are the most effective non-physical ways to 'touch' a client?
(v) To what extent is the subject of touch addressed in counselling training, both theoretically and experientially?
(vi) What are the optimal conditions in which the physical and spiritual can combine in pastoral counselling?

In the final section, I offer suggestions on which aspects of the use of touch are particularly relevant to the wider field of pastoral care.

9. Touch in pastoral care

> Christ has no body now on earth but yours . . . Yours are the eyes through which is to look out
>
> Christ's compassion to the world . . .
>
> Yours are the hands with which He is to bless men now.
>
> *St. Theresa*[74]

Pastoral counselling is a narrow band in the much wider spectrum of pastoral care and the issues surrounding touch in pastoral care are essentially the same as in pastoral counselling. What applies inside the counselling room applies equally well outside it, as the chaplain in my introduction demonstrated. Touch can be seen in the context of part of a *whole* ministry to people who are also *whole* in the sense that what happens to one aspect of them, whether body, mind or spirit, can affect the other aspects.

For example, there are some times when spiritual comfort and hope can be mediated through touch as meaningfully as by a prayer at other times. Is it not generally accepted that quietly holding a bereaved person's hand or putting an arm round their shoulder can express care and support while at the same time acknowledging the inadequacy of any words in the face of their tragedy?

> *A nervous elder confided with some surprise that one of his members had told him that his arm on her shoulder had been the best thing anyone had 'said' to her after her husband died.*

For the majority of those 'officially' involved in pastoral care, the use of touch represents a minor but maybe nevertheless significant part of their ministry. However, there are many Christians in the social and health care fields whose daily work involves at least in part the bodily care of the elderly, the sick, the disabled, the dying, or the bereaved. While most carers may not regard the work they do as primarily pastoral care, when it is done with love and compassion, are they not demonstrating Christ's love and concern and acting as Christ's body on earth?

Many of the 'cared for' are in multiple loss situations; the primary loss inevitably spawning a cluster of secondary losses. For some of these people, and maybe more than would care to acknowledge it in our prevailing non-touching culture, one of the secondary losses is that of touching and being touched. This can result in 'skin hunger', a craving for touch every bit as real as the craving for food when the stomach is empty. This is not surprising when we recall that Harlow's monkeys actually spent their time near a cloth mother in preference to a wire mother who lactated. Thus part of the care needed by many of

these people in loss situations may be that of nurturing touch, a replacement for the touch they have lost, and it is often possible for the carer who is aware of this to provide touch in an appropriate manner.

With the diminution in their other senses, particularly sight and hearing, the elderly, if not too inhibited, can be especially dependent on touch for keeping in contact with the world and with their peers. Many elderly people living alone can go for days without being touched. Imagine the possible effect of this change on a widow or widower who has been happily married for many years. In this case the carer's touch can play a vital role in helping the elderly person, particularly the confused elderly, feel they are still alive. In the case of the latter, touch is in fact a more real form of communication than speech. It is as though they have regressed to a preverbal state.

Social and health care workers who are sensitive to the need of many in their care for touch can also have a vital role to play in their patients' well-being. The sick, the elderly, the dying are all, whether temporarily or permanently, in a state of increased dependency, often accompanied by anxiety and isolation. Appropriate touch can help to allay the fears and break through the isolation. This can happen, for example when a nurse explains a procedure while holding the patient's hand, when an auxiliary listens as she washes a patient's back in the bath, when a physiotherapist massages the legs of a patient on a respirator. All these are small but significant ways in which love and care can be conveyed non-verbally.

Autton's excellent book *Touch: An Exploration*[3] contains chapters on touch 'in the care of the sick', 'in stress and crisis situations', and 'in the care of the aged, the dying and the bereaved', all of which provide helpful and informative reading, interspersed by illustrations. Here is an example of my own. Alice was an elderly member of our fellowship group whom I did not know very well. Her health had deteriorated and she has recently been moved from her home into a geriatric hospital. One Sunday it fell to me to take her the church flowers. That visit was one of the most meaningful I have ever made.

> *When I arrived she was dozing restlessly. She did not know me. So I took her hand and held it, and very quickly we seemed to be communicating at some deep unconscious level. As I silently prayed for her, she gradually drifted off into a peaceful sleep. After a few minutes I tried very gently to extract my hand, but although by her breathing she appeared to be asleep, her hand seemed to be very much awake. I was aware of her grip tightening as if she were saying 'Don't go yet. What's another few minutes of your lifetime? You've plenty left. I haven't much. I can hardly speak now. But I know you're there. And I feel safe holding your hand. So please wait a bit longer, if you can spare the time.' She died a few days later.*

Safety for both ourselves and those to whom we are ministering can lie in travelling along the paths we know and feel comfortable with,

and there will be those who over many years have developed their own approach to touching. For the less experienced, and those of us who wish to extend and develop our use of touch in pastoral care, we need to give ourselves permission to respond to God's promptings in ways which may be new to us. To *always* wait to check out our ideas may be to lose opportunities. And if we regard the inevitable mistakes we will sometimes make as learning opportunities rather than as failures, then our confidence will increase and our pastoral care will become increasingly sensitive and appropriate.

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